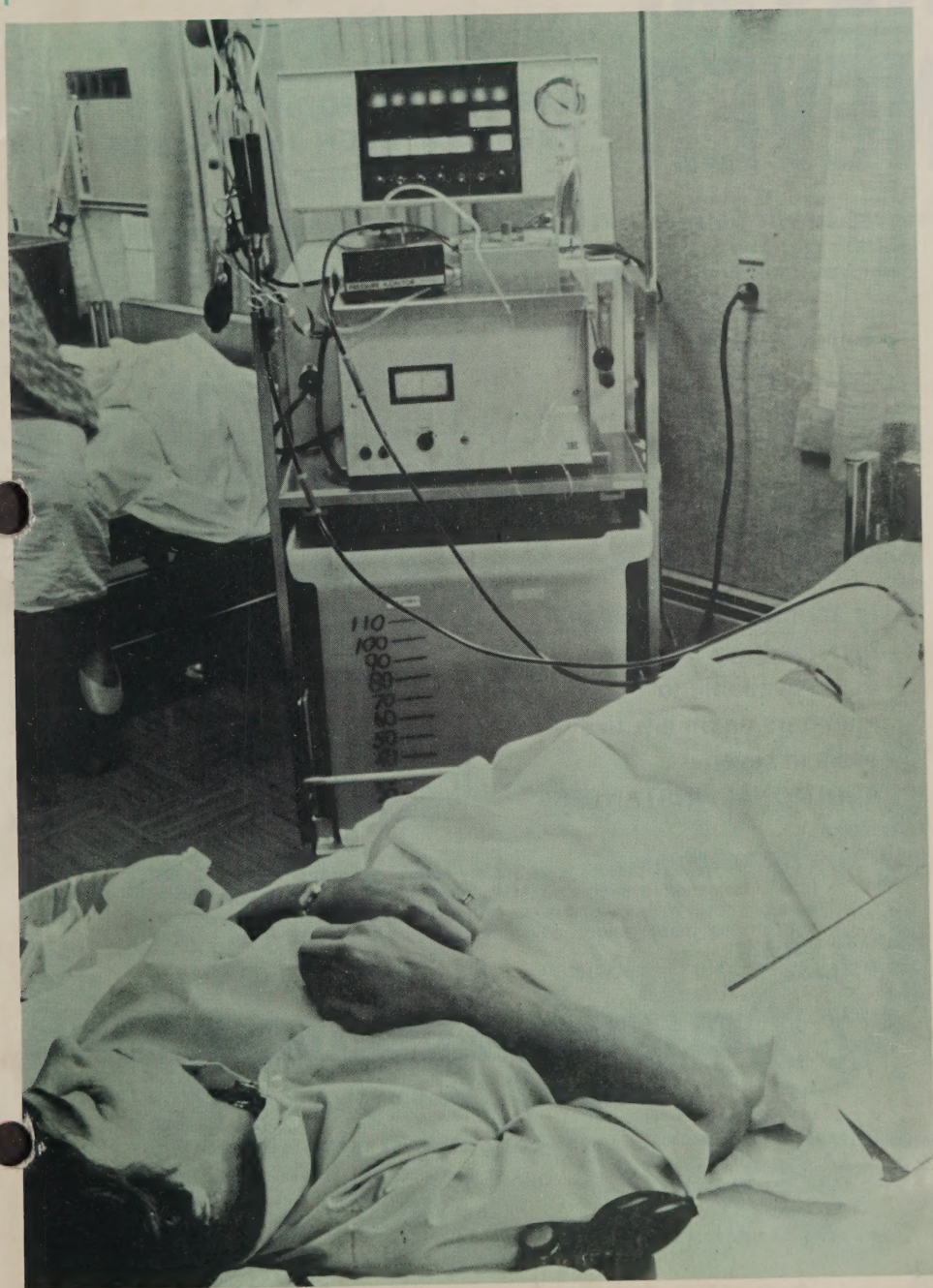


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EDITORIAL

WELFARE "ECONOMY"

Hampden District is most fortunate in having within its borders an outstanding renal dialysis unit, sponsored by the Susan A. Auchter Fund and located at the Springfield Hospital. Elsewhere in this issue is a description of this outstanding facility written by its Director, Dr. Alan R. Gerstein. Not mentioned in the latter's article but most important are the financial considerations involved in so complex an operation. While the Susan A. Auchter Fund set up this unit, the operation of the unit including the salaries of personnel and the needed supplies requires vast sums of money. There can be no price tag on health and human life, and Dr. Gerstein was asked how the renal dialysis unit is financed. His reply follows:

"Our estimated cost per hemodialysis, once our unit has grown to full size is \$175, and that is what we are charging our patients presently. At 3 dialyses per week, this is \$525 per week or close to \$30,000 per year. On home dialysis, the only cost per patient would be the disposable supplies; they would run to something in the neighborhood of \$50 per dialysis or approximately \$7,500 per year. The patients who are accepted on chronic dialysis are obviously terminally ill; however, once they have been on dialysis for about a month, they generally feel well enough to return to work."

The Welfare Department has so far been very cooperative and has not turned down a single patient who has been sent to them for support. I am unaware of the details of the operations of the Welfare Department, but as I

understand it, some of the patients are on general welfare; others receive Medicaid. The rules under which the Welfare Department is operating at the present, however, are interpreted to prohibit support of home dialysis. Therefore, the Welfare Department is paying \$30,000 per patient instead of \$7,500 per patient. If this policy is continued, we will soon have a filled unit and will be unable to accept new patients. Furthermore, the Welfare Department requires that all patients receiving such aid be permanently and totally disabled, and thus prohibits patients from returning to work. This is obviously undesirable from both the financial point of view and also for the emotional rehabilitation of the patient and his family. The Veterans Administration funds patients with service connected disability without such stringent rules, but obviously most of the patients do not qualify for this kind of care. The Massachusetts Rehabilitation Commission also has much more liberal rules, but they will only fund patients who are going to receive kidney transplantations at the Peter Bent Brigham and many of the patients do not want transplants at this time."

It would appear therefore, that the Welfare Department is paying the lion's share of the cost. This is very commendable. Nevertheless, one wonders why the Department is "economizing" by refusing to pay \$7,500 per patient annually for home dialysis, which would permit a patient to work and also to free a hospital bed. Instead the Department willingly pays \$30,000 annually for hospital treatments and precludes their engaging in any gainful occupation. Aside from the practical economics of this bizarre policy, the effect of such a policy must have its psychological impact on a patient rendered unnecessarily disabled. Furthermore, this policy requiring the use of beds by patients who might otherwise be treated at home may result in short order of depriving other patients requiring dialysis treatment because of lack of beds.

The project is new and perhaps it takes time to iron out many problems. However, it is earnestly hoped that the officials responsible for Welfare regulations will see the light, and at least as they pertain to renal dialysis, change the rules. Refusal to pay for home dialysis does not constitute economy.

Tillman

COVER: *Patient with shunt in left leg attached to a hemodialysis unit.*

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THE SUSAN AUCHTER RENAL SERVICE

by Alan R. Gerstein, M.D.

When Susan Auchter died, her family and friends realized that her life might have been saved if the latest methods of care for patients with kidney disease were available locally. Rather than despairing at this perhaps unnecessary death, they sought to change the situation. Thus was born the Susan A. Auchter Fund. The results of their work and the community support which they received are now available to the people of the Hampden County area.

In March of this year the first patient was started on chronic hemodialysis at The Springfield Hospital. Three months later, work on the new hemodialysis unit was completed; the center was officially opened; and the two patients then on chronic hemodialysis moved from a regular hospital room to the new 4-bed hemodialysis unit. By October, one patient had received a kidney transplant in Boston after being maintained on the artificial kidney in Springfield, and six patients were being maintained on chronic hemodialysis.

The goal of the Susan Auchter Renal Service is to eliminate death from kidney disease in this community. Although the achievement of such a goal is a long way off, a start has been made in that direction. All patients with terminal uremia in this

community can be offered a chance for life saving, long-term treatment, and for those who are interested and suitable, kidney transplantation can be arranged elsewhere.

Hemodialysis is not new. It is a quarter of a century since Kolff developed the first successful artificial kidney in Holland during the second world war. It is a decade since Scribner and his associates in Seattle began treating chronic renal failure cases on a long-term basis with the artificial kidney. At first this was a research procedure and only "ideal" candidates were considered for this form of treatment. Recently it has been recognized that most people with chronic renal failure can be helped by this sort of treatment. Although younger patients and those with fewer unrelated diseases are apt to do best on chronic dialysis, patients with terminal renal failure must either die or be dialyzed, and we feel that dialysis is worth a try on all such patients. The Susan Auchter Renal Service, therefore, hopes to offer this as a routine form of treatment to anybody who might benefit.

The criteria for acceptance on the unit are relatively simple. The patient must have progressive, near terminal, renal failure. The patient must have no other unrelated fatal disease or other medical complications so

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severe as to make prolongation of life unattractive. The patient must have no unrelated emotional problem so severe as to prevent cooperation with the dialysis program. Finally, as will be discussed below, some way of paying for the patient's treatments must be found.

HEMODIALYSIS

The actual process of hemodialysis is quite simple. Plastic cannulae are inserted into a peripheral artery and vein to provide easy access to the blood stream. Between dialysis the arterial and venous cannulae are connected to allow a constant flow of blood, thereby preventing clotting in the cannulae. At the time of dialysis, the arterial and venous cannulae are connected to the appropriate tubes on the artificial kidney machine. The patient's blood is then pumped from the artery into the hemodialysis coil.

In the coil the blood passes through flat cellophane tube. The artificial kidney itself is simply a 120 liter tank filled with tap water and chemical concentrate which make a solution chemically identical to normal extracellular fluid. The artificial kidney contains a pump which forces this dialysis fluid past the cellophane tubes at right angles to the flow of blood.

A thin sheet of blood flowing through the machine is thus separated from a fluid resembling normal extracellular fluid only by the cellophane membrane. Cellophane con-

tains microscopic pores large enough to allow simple chemicals to pass through, but too small to allow cells, bacteria, viruses, or protein molecules to pass. As the blood flows through the cellophane tube, any small chemical constituent in higher concentration in the blood than in the dialysis fluid passes through the pores in the cellophane. In this way the waste products present in excess in the blood diffuse into the bath fluid and are washed away down the drain. Blood then flows out of the cellophane tube, through a plastic tube, and back into the patient's vein. During the usual 6-hour dialysis, the BUN and serum creatinine fall to near normal values. The process is repeated 3 times a week.

Over a prolonged period of time dialysis relieves most, but not all, of the symptoms of uremia, and prolongs life indefinitely. The common symptoms of uremia — anorexia, nausea, vomiting, weight loss, mental changes, coma, and convulsions — can be readily relieved. Anemia tends to persist, the patient remains somewhat weak, and sexual fertility and impotence persist. Itching and peripheral neuropathy, two troublesome symptoms of chronic renal failure, do not develop in patients on chronic dialysis, but if present before chronic dialysis is begun, they often persist unchanged.

Treatment results in a patient who is able to perform normal activity, who is able to go to work and support

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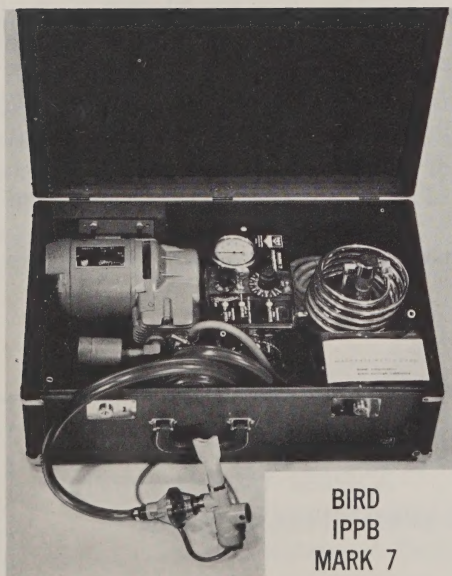
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his family, but who feels less than perfect. The treatment is relatively safe and the patient can live indefinitely. For many patients this is satisfactory; for others this is not adequate and in these cases, kidney transplantation can be considered. When successful, the transplant patient is completely rehabilitated, but transplantation is sometimes not successful and has a much higher mortality rate than artificial dialysis.

The artificial kidney has certain drawbacks. Among the most important are the high cost per treatment and the requirement that the patient return three times a week for the rest of his life, for the treatment. These problems can be partially relieved by allowing the patient to dialyze himself in his own home. This approach greatly reduces the cost per treatment and also reduces the inconvenience associated with repeated treatments since the patient can treat himself according to his own schedule rather than to follow the hospital schedule.

AVAILABILITY

The hemodialysis unit at The Springfield Hospital is a 4-bed unit. Since the treatments last 6 hours and since patients come 3 times a week, 8 patients can be handled during one nursing shift. By expanding to two shifts a day, it will be possible to accommodate 16 patients. National statistics indicate that approximately 26 new patients reach the terminal stage of renal disease every year per million population. In the greater Springfield area, with the total population of a little over 500,000, we might expect about 15 new candidates for chronic hemodialysis each year. If we are successful in prolonging the lives of each of these patients indefinitely, the capacity of the dialysis unit might soon be reached. By

using the unit to train patients for approximately 3 months for home dialysis, rather than to treat them in the hospital indefinitely, it will be possible to handle all the patients in this community who need chronic hemodialysis. For this reason, the Susan Auchter Renal Service has selected the liberal criteria for patient selection described above.

The major problem that remains is financial. The highly skilled personnel needed and the large amount of disposable supplies used, make hemodialysis a very expensive procedure. The cost is well beyond the means of the great majority of potential patients. The funds raised in the community to start the Susan Auchter Renal Service were adequate to buy the equipment, renovate the area, and pay the personnel for a limited period of time. However, funds are not available for the great expense of maintaining patients. Therefore, in almost every case outside funds must be sought to maintain a patient. For some patients private insurance is available. In certain selected instances, The Veterans Administration or the Massachusetts Rehabilitation Commission will pay for this treatment. In most cases, however, the Welfare Department must pay for dialysis, and Welfare Department rules create financial problems for the average middle class person who is forced by his disease to seek funds from this source.

The hemodialysis unit is now ready to accept new patients and will continue to grow to meet the needs of the community. Chronic hemodialysis offers the hope of prolonged productive life to patients afflicted with chronic kidney disease. The Susan Auchter Renal Service at The Springfield Hospital offers this opportunity to every patient in the greater Springfield area.

SUCCESSFUL P.R.

by Lester G. Suzor, M.D.

Chairman, Public Relations Committee

Many great changes have occurred in the past few years, especially in the attitude of groups. We have seen the effects of peace drives, campus riots, hippies, burned down neighborhoods, government leaders forced into retirement, permissiveness in books and movies — an entire revolution of outlooks on our world.

We are living in what is called the "Age of Unreasonable Expectations." Everything has gone so well for most of our population — and this has been so visible to the people who do not have all the benefits they see — that expectations now are becoming demands without thinking what must be accomplished to bring about our next round of bounties.

Discipline has been deleted from our lives. This generation believes that desires and impulses have to be honored. Miracles can occur just by wanting them with a belligerent attitude. Many of our people now think they can see the promised land because it has been promised to them so freely.

CHANGE

Medicine, particularly, is faced with the problems created by its own success. Until our own generation, man lived with certainty that death was just around the corner. Good health was the most uncertain of all our blessings. Now that science and the medical profession have made great strides in preventing and overcoming disease, that corner of death is a few extra blocks away and our people want and often demand by coercion the best medical care we can offer.

Of course this is unreasonable in light of what is available to meet the needs and the time and the effort it takes to catch up with such surges of demand. But let's remember that throughout history, in times of famine, when no one could increase the supply of bread, people rioted in demanding bread.

So medicine is faced with some problems created by its own success. When you succeed at anything you improve things and improvements automatically creates changes and change then challenges our success.

The great problem of our age is, now that we created change, how do we live with, direct and master it rather than have it overwhelm us and destroy the fundamentals that made our success possible.

Public relations is a bridge to change. It is a means to adjust to new attitudes that have been caused by change. It deals with the problems of communication between changing groups.

We now have a population with more years of education than people have ever had. But this success has also created problems. Almost everyone has the "little learning" that Alexander Pope said was a dangerous thing. In medicine people now know just enough to be demanding and critical; to expect too much. Where they used to suffer in ignorance or medicate themselves, they now feel they know enough to determine how medicine should be practiced.

In the health field, the birth of whole new concepts and techniques makes it impossible to maintain the

NEXT MEETING
OF THE
HAMPDEN DISTRICT MEDICAL
SOCIETY



TIME: Tuesday, February 4, 1969
Business Meeting at 6:30 P.M. fol-
lowed by Social Hour and Dinner
(Courtesy of Society) at 7:30 P.M.

PLACE: Storowton Tavern, Stagecoach Barn
West Springfield, Massachusetts

PROGRAM: Speaker, John W. Norcross, M.D.,
President, Massachusetts Medical So-
ciety

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simple and easily understood patterns in which most physicians began their medical careers. The trick is to guide and direct this changing profession in orderly evolution to avoid having it taken over by the most ponderous, the most wasteful, the least professional factor in the health care spectrum — the federal government.

AN APPROACH

The medical profession is now faced with defending itself on other people's terms. Remember that counter-punching never succeeds. In public relations initiative is everything. We must assess what needs to be done and devote the dedication of medical people to doing these things.

Let us motivate actions to continually improve our health care system on stream with the desires of the public. Medicine will then be the master rather than the victim of change.

Let us master the extremely com-

plex factors of modern communication to gain understanding and acceptance.

We must accept the fact that medicine and health care will constantly be spotlighted, often erroneously and unfairly. We must expect this and not hope to respond to each comment or misinformed accusation. All the energies of the profession can be dissipated in trying to respond to the initiatives of others, thereby failing to accomplish the vital initiatives of its own.

What are some of the factors in the health care picture that medicine needs to get across to America?

First, much of America's health problem arises from patients' own neglect; the refusal of thousands of mothers to get care before labor, to follow a proper diet, to avoid drugs, alcohol and other abuses; the gross intemperance of our affluent people in eating, drinking, smoking and avoid-

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ing exercise; the widespread failure to follow the doctor's advice; the high accident rate and the pollution of air and water. Medicine is blamed too much for infant mortality, heart attacks, cancer, accidents and violence that Americans bring on themselves.

Second, health care today is a system with many elements, not just the physician with his black bag and a few nostrums. It includes the doctor, the patient, the medical schools, hospitals, auxiliary personnel, nursing homes, insurance companies, drugs, sophisticated equipment, the atmosphere we live in, public attitudes, dollars and government.

All these factors are interrelated and must be in balance. If any of them gets too much push, all of them may be imbalanced. Too many patients all at once and too many dollars pumped in can create intolerable stresses. Massive attention to Medi-

care and Medicaid grossly distorts the whole system.

Third, people tend to see "health care" as meaning the medical profession, therefore, the doctor. The doctor is blamed for the problems of the medical schools in failing to enroll more students, of the hospitals for their soaring costs, of the drug manufacturers, the pharmacists, the nurses, the government health centers and other factors they have little control over.

Let us stress the separate responsibility of the physician; the improvement of health care; demonstrate our efforts to keep fees reasonable; make efficient use of hospitals; and concern ourselves with the costs of drugs.

Above all, let us urge enforcement of the highest standards of ethics and practice that will justify medicine's claim to being best able to direct the health care of the American people.

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TUESDAY, FEBRUARY 11, 1969

SPEAKER: Edwin O. Wheeler, M.D.
Cardiologist
Massachusetts General Hospital

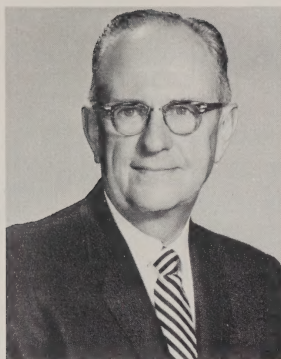


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CONVALESCENCE FROM
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CLINIC: Providence Hospital, 5:00 P.M.

PRESIDENT'S PAGE

OUR CONTINUING CHALLENGE



In present day society we are hearing more and more about "Information gaps" — "Poor public images" — "Lack of communications" — "Misunderstandings" — "Distrust and fear" — between the public, politicians and government. It is small wonder that we as physicians are accused in much the same manner, and at times rather violently attacked by the press. Many of us often wonder why our image should be in question when the rapport we enjoy with patients we see daily seems so satisfactory and rewarding in understanding and mutual respect.

Expanding technology has resulted in few personal relationships. Preventive medicine plus more effective treatment have eliminated many of the old fears of contagious and other diseases and as a consequence, an information gap occurs with its attendant distrust, often as a result of a knowledge gap which may never again be bridged.

Is there a solution to our dilemma? I think so, but it's not easy. We must learn to fathom human actions and reactions in the sphere of all age groups and develop new ways to serve mankind. The present energetic efforts of the Public Relations Committee under Dr. Lester Suzor in attacking drug abuse among our own young people, is an example of a new and imaginative approach. Is anyone better equipped to handle this big problem than the well informed physician?

So I charge you to watch, listen and study so as to better analyze the actions and thoughts of your fellow man. Learn more about his needs, failings and dangers and imaginatively develop new approaches and techniques that we may effectively serve the public with a concerned humility.

We have so much to learn.

A handwritten signature in dark ink, appearing to read "W.C. Barnes".

WAYNE C. BARNES, M.D.

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Morris J. Ritchie, M.D.
1902 - 1968

Dr. Morris J. Ritchie of 39 Mountain View Street, Westfield, died at the Noble Hospital on December 22, 1968.

Born in Chelsea, Mass., on November 17, 1902, Dr. Ritchie graduated from Harvard University in 1923 and received his doctorate in medicine from the Boston University School of Medicine in 1927. After interning in the Waltham Hospital, Waltham, Mass., and the Monmouth Memorial Hospital, Long Branch, N. J., he went on to serve a four-year residency in surgery at the Murry Hill Hospital in New York City. Upon completion of his residency in 1934, Dr. Ritchie came to Westfield, where he practiced his specialty of surgery until his retirement in 1956.

Dr. Ritchie served on the medical staff of the Noble Hospital in Westfield for many years. He was a member of the International College of Surgeons, the AMA, the MMS, and the HDMS. During World War II, Dr. Ritchie served in the Medical Corps of the U. S. Navy.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

MARK YOUR CALENDAR NOW!

HDMS MEETING, FEBRUARY 4

HDMS EXECUTIVE COMMITTEE MEETING, FEBRUARY 18 AND
MARCH 18

MMS COUNCIL MEETING, BOSTON, FEBRUARY 12

AMERICAN ACADEMY OF OCCUPATION MEDICINE, BOSTON,
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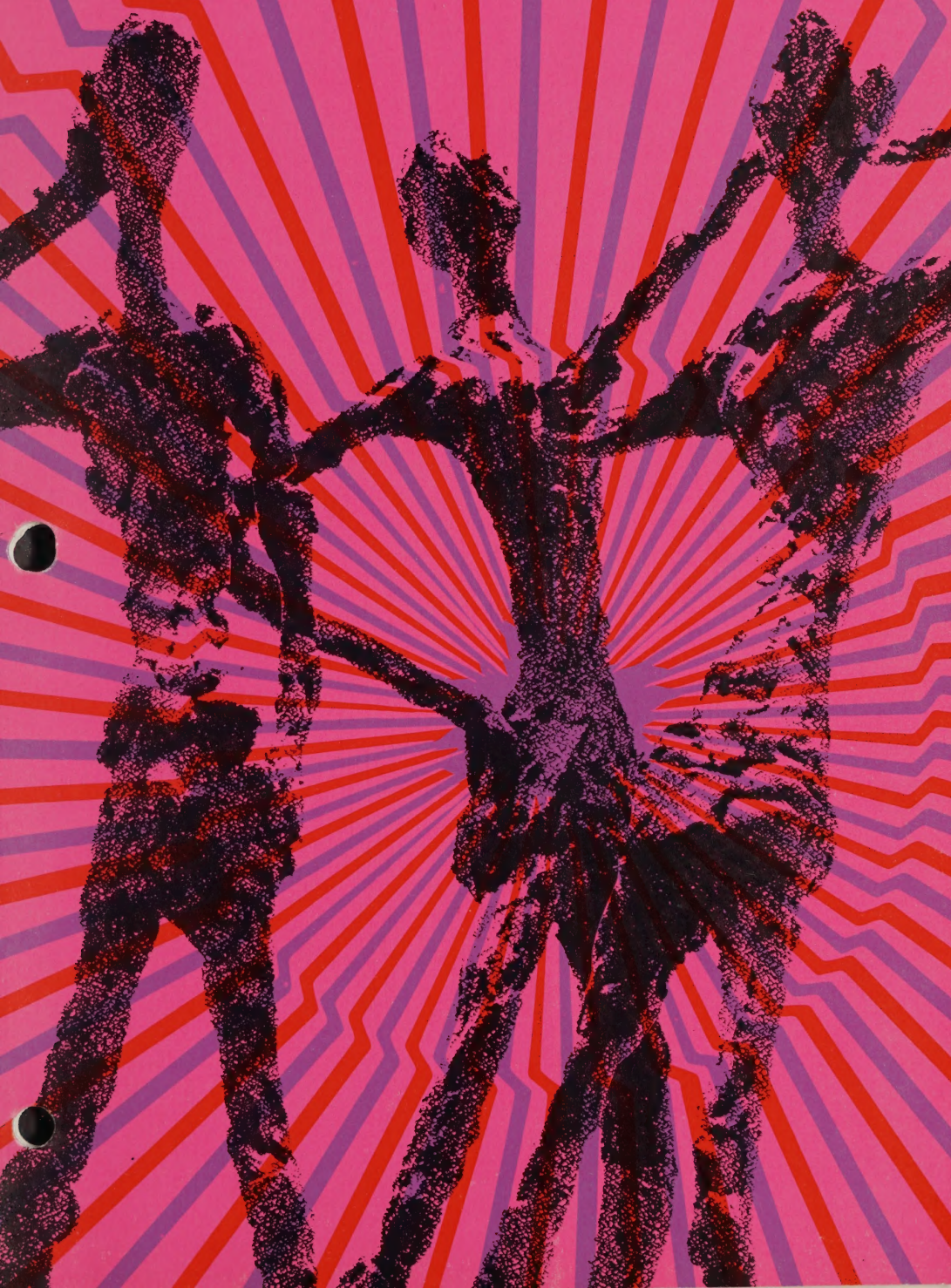
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26-MARCH 2

AMERICAN COLLEGE OF SURGEONS (SECTIONAL), JOINT MEET-
ING FOR DOCTORS AND NURSES, BOSTON, MARCH 10-12

MMS ANNUAL MEETING, BOSTON, MAY 27-29

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MIAMI BEACH-1968

Many forward steps were taken by the AMA House of Delegates during 10 hours and 47 minutes of deliberations in convention at Miami Beach from December 1 to 4. Attendance at the House sessions went from a low of 91% at the opening meeting (223 of 242 delegates present) to a high of 99% (240 delegates) at the Tuesday and Wednesday sessions when actions were taken. Ninety-four items of business were brought to the attention of the House, including 22 reports from the Board of Trustees; one from the Joint Conference Committee of AMA and Blue Shield; four from the Council on Medical Service; three from the Council on Medical Education; two from the Council on Constitution and Bylaws; and 62 resolutions from state medical associations, scientific sections and individual delegates.

Of the 32 reports, 18 were adopted; three were amended and adopted; eight were accepted for information; one was amended and then accepted for information; one was approved; and one was rejected. (The House did not pass the Constitutional and bylaw amendments that would have enlarged the Board of Trustees to 16 members by giving the Vice President a vote on the Board.)

Of the 62 resolutions, 12 were adopted; 19 were amended and adopted; six were combined with one or more others into substitute resolu-

tions; three were absorbed into other adopted resolutions; six were referred to the Board or a Council; five were rejected; six were replaced by substitute resolutions, three were replaced by substitute resolutions which were then amended; and two were withdrawn before being sent to a Reference Committee.

DISCRIMINATION

The Council on Constitution and Bylaws presented wording for the anti-discrimination amendments in response to the House's wishes expressed at the Annual Convention in June, 1968.

The over-all statement on discrimination was added as a new Section 3 of the Bylaws, Chapter I:

Section 3—Discrimination in Membership

Membership in the American Medical Association or in any of its constituent associations shall not be denied or abridged on account of color, creed, race, religion or ethnic origin.

Provision for disciplinary action was provided by adding this sentence to Chapter XI, Section 11, (D) (7):

If the Council determines that the allegations (of discrimination against physician applicants for membership) are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

The New England delegates, particularly those from Mass., were most instrumental in bringing these amendments into reality.

OSTEOPATHY

The House adopted a Board report stating these objectives with respect to osteopaths:

To "assure the provision of the best possible health care to the American people; make available to students and graduates in osteopathy, education of the same high standards as prevail in undergraduate, graduate and continuing educational programs in medicine; provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine."

To achieve those objectives, the AMA recommends that each school of osteopathy improve its teaching program by strengthening its faculty and improving its facilities and resources; invites schools of osteopathy and their accrediting agencies to consult with the AMA and the Association of American Medical Colleges; suggests that accredited hospitals may accept qualified osteopaths on medical staffs; suggests that medical specialty boards may accept osteopaths for examination if they have completed AMA-approved internships and residency programs and have met other regular requirements; requests that as specialty boards declare intent to permit examination of osteopathic graduates, appropriate AMA-approved residency

programs be opened to qualified osteopathic graduates; suggests opening AMA-approved internships to qualified osteopathic graduates; recommends that determination of qualification be made at the level of the medical staff, the county medical society or the review committees and boards having appropriate jurisdiction; and suggests that AMA, state and county societies and other affected organizations "may proceed to make such constitution and bylaw changes as are necessary to implement the foregoing."

The House also "suggests that each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association" and instructed the Council on Constitution and Bylaws to prepare "appropriate Bylaw amendments so that qualified Doctors of Osteopathy may be admitted to full active membership" in the AMA.

PRESIDENT'S REPORT

Dwight L. Wilbur, M.D., President, told the House that "Perhaps our greatest problem is that, in many ways, we in America have tried too hard and succeeded too well We have progressed so far in so many areas that our people are impatient with the realities of human limitation. They are eager to instantly wipe out poverty, eliminate ignorance, sweep away ill will and violence, replace jealousies and hate with universal good will. Even the specter of death

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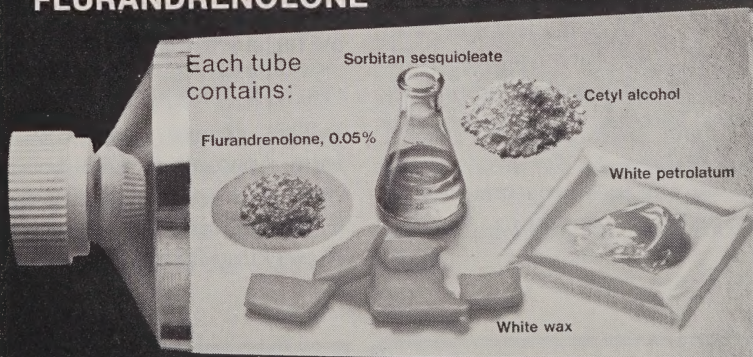
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itself is by some considered a temporary and stubborn spite to mankind that will be mastered as soon as new organs are developed or transplanted and new drugs are synthesized."

President Wilbur listed five areas to which he believes the medical profession should give its greatest attention:

1. Making high-quality health care available for everyone in America at as reasonable a cost as possible.

2. Putting a rein on costs by avoiding hospitalizing any patient unless absolutely necessary; reducing the length of hospital stay to the essential minimum; using extended care facilities, nursing homes and home care services more often; stimulating prepayment mechanisms on a voluntary basis; supporting the principle of income tax credits for health insurance; keeping physicians' charges on a basis of usual, customary and reasonable fees, with self-discipline and peer review; and encouraging wider use of reliable automated laboratory procedures, passing the cost benefits on to patients.

3. Developing more reasonable and more realistic expectations by the public.

4. Unifying the medical profession and maintaining constructive liaison with other groups.

5. Planning for an orderly and enhanced future. "We must," he said, "increasingly depend on the Board of Trustees to lead in planning and development for the future As an association, this is our greatest responsibility. The Board must increasingly be an informed board of strategy that looks ahead and advises the profession, the government and the public regarding health measures."

The President closed his report by saying, "We are immersed in an epoch of change. We cannot hope to emerge from it as respected leaders unless we guide the course of change Our guidance in helping change all elements of society that affect the people's health in an orderly, balanced sequence is the price of our continued esteem as a profession and an organization."

ORGAN TRANSPLANTS

The House approved the Uniform Anatomical Gift Act and urged each state medical association to give it careful consideration "with a view to seeking its adoption in its state."

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State associations were urged to consider carefully the provisions of the legislation and to make any necessary changes to accommodate their needs. The uniform act has been approved by the American Bar Association through the Liaison Committee to the ABA and the House supported co-operative efforts by state medical associations and state bar associations to secure prompt adoption of the legislation.

HEALTH CARE COSTS AND FINANCING

Following its similar action at the 1968 Annual Convention, the House again accepted for information the report of the Committee on Health Care Financing pertaining to the use of federal income tax credits for the purchase of health insurance and adopted a resolution that the AMA "vigorously promote the enactment of federal legislation which would translate the concept of income tax credits for health insurance premiums into law."

The House asked the Board of Trustees to devote sufficient staff, facilities and funds to develop an "effective program for immediate and on-going studies of health care costs"

and to report the status of the program at the 1969 Annual Convention. The Board also was requested to expedite and expand existing programs and, "where necessary, develop new programs for the following purposes: (1) analysis of health care costs and expenditure data developed and reported by other sources; (2) definitions, reports and explanations of the several major categories of health care expenditures; and (3) dissemination of the data, findings and conclusions of such studies to constituent medical societies, news media and state and federal governmental authorities."

Recognizing that advertising and promotion of new Blue Shield programs providing broader benefits might be subject to misinterpretation by the public, the House resolved that "any references to 'paid-in-full' coverage clearly identify those services which are indeed covered on a 'paid-in-full' basis and also identify the circumstances under which those services must be rendered."

In two other actions, the House called on "all voluntary health insurance organizations to offer reinstatement of all contracts which were cancelled or converted because the insured individual was over age 65 and eligible for" medicare; and reaffirmed the AMA's belief that "the concept of voluntary health insurance is the most acceptable means of financing health care when applied in keeping with the principles of the AMA."

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EDUCATION

The House adopted the Council on Medical Education's "Special Requirements for Residency Training in Family Practice" and resolved that the AMA "affirm the importance of providing appropriate recognition for family physicians through approval of a primary specialty board for family practice and that the Council on Medical Education be encouraged to continue its efforts with the American Academy of General Practice and the AMA Section on General Practice to achieve this goal."

A program for formal recognition by the AMA of physicians who participate in continuing medical education was adopted, along with a proposal to fund the recognition award. "A physician may, upon request," the report said, "receive the recognition award at the completion of three years of graduate training in AMA-approved programs, or the equivalent in research activity or in educational programs leading to further advanced degrees in medical sciences." Funding will include a registration fee of \$5 for each physician who wishes to participate. The fee would cover the costs of printing, handling, mailing and processing the correspondence and certificates as well as the costs of initiating and maintaining the record system. Each physician would pay the registration fee only once in each three-year period.

ALLIED HEALTH PERSONNEL

The House agreed with the Council on Health Manpower regarding the need for physician prescription and supervision of all ancillary services provided in the hospital by adopting a Board of Trustees report on the utilization of paramedical personnel. In adopting the report, the

House stated that "the medical staff should concern itself with contractual agreements between various allied health professionals and the hospital only insofar as, and to the extent that, such agreements tended to remove the provision of ancillary services from the prescription and supervision of the physician."

Another Board report adopted by the House, based on findings of the Council on Health Manpower, considered the phrase "related healing arts" as used in the declaration of purpose in PL 89-749. The report stated that "it is apparent that the context in which this term is used offers assurance that the patterns of medical practice in the country will not be altered by PL 89-749." Consequently, the Council recommended "that any definition of the term 'related healing arts' should be made at the state and local level because of the important variations in practice within the country."

MEDICINE AND THE GOVERNMENT

The following resolutions were adopted by the House:

. . . That the AMA "seek to have Congress phase out federal health care programs which overlap and duplicate Medicaid."

. . . That PL 89-749 be amended to require that "a substantial percentage" of executive boards or councils" at all levels of planning, federal, state and regional, both A and B agencies, be actively practicing private physicians, nominated by organized medicine."

. . . That county and state medical associations, through the AMA, supply when requested "the names and biographical data of physicians who are qualified, willing and able to accept appointment in government

service, full or part time."

... That the Board of Trustees "consider sponsorship of periodic conference or workshops on public affairs for the continuing education and benefit of medical society leaders and physicians throughout the nation."

... That the AMA "exert every effort to bring about the elimination of unnecessary documentation of medical services by the physician, hospital and fiscal intermediary on Medicare and Medicaid patients."

... That all school administrative bodies be encouraged to consult with "competent medical authorities prior to initiating and conducting programs involving any medical aspects funded under the Elementary and Secondary School Act."

... That "physicians and their medical societies should strive to attain the adoption of established principles which are designed to provide the people of this nation with the highest quality of medical care" and that all physicians be reminded "that as free men and women they have no obligation to accept employment and remuneration under any conditions other than those arrived at by agreement between the physician and the recipient of his service."

DR. BLASINGAME

Following the adoption of three resolutions commending F.J.L. Blasingame, M.D., for his services to the AMA as delegate, trustee and Executive Vice President, Dr. Blasingame addressed the House briefly at its opening session.

He called for a constitutional convention to re-evaluate the working of the AMA to equip it better for the "Herculean tasks" it faces, adding that the existing committee system is inadequate for the work. "This is a

time for action, clarification and soul-searching for the AMA," he said, adding that the Association "can't afford to be concerned with internal bickering."

Dr. Blasingame said several questions should be asked by the AMA of itself, including these: How can the organization discharge its primary obligation as advocate of physician responsibility? Is the organizational structure adequate to meet the obligations of modern science? How can priorities be established to help both the physician and the patient? How can a dichotomy be avoided between the scientific and political aspects of medicine?

MISCELLANEOUS

Other resolutions adopted included these:

... That the House go on record "favoring exploration of" establishing more uniform reciprocity arrangements among all states with respect to physician licensing.

... That the AMA adopt the following distributions:

"Usual" is defined as the 'usual' fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee); 'Customary' is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socio-economic area; 'Reasonable' is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question."

The House also resolved that "whenever these terms are used in contracts or laws, that they be specifically defined in those documents."

HAMPDEN CAPSULES

SPEAKING

Dr. Kendrew spoke to 70 clergymen on "Drug Abuse" and was "side-walk interviewed" after the meeting by WHYN, Channel 40.

Dr. Levin-Epstein spoke at a meeting of Hampshire-Hampden Association for Children with Learning Disabilities in Westfield. His topic was "The Pediatricians' Viewpoint of Children with Learning Disabilities."

Dr. Howard Turner, Dr. Harold Williams and Dr. Kendall participated in the symposium on pulmonary disease held recently at the Springfield Hospital Medical Center.

Dr. Riley spoke to the Mother's Club at Cathedral with "Parents to Child about Sex."

Dr. Shuman was the principal speaker at the Annual Meeting of the Wesson Maternity Hospital.

HOT FLASHES

Dr. Greenspan has been elected to membership in the American Society of Internal Medicine.

Dr. Simpson has left private practice to serve full time as Medical Di-

rector at Monarch Life Insurance Company.

Drs. Polchlopek, DeLaurentis, Griffin, Schwendenmann and Frankl attended the American Heart Association Annual Meeting held in Bar Harbor, Florida.

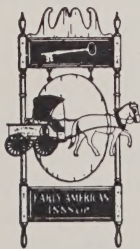
Dr. Adham spoke on Cryosurgery at Dentistry Conference in Boston.

Dr. Platt and Steinberg attended a special session on Rheumatic Diseases.

Drs. Bernstein, Borenstein, Daly, Green, Whitney and Cooper participated in panel discussions at the Passionist Monastery in West Springfield through the Northeast branch of the APA. These were on Medicine and Religion.

HEALTH FAIR, '69—"YOUR RESPONSIBILITY"—the big undertaking of HDMS. March 26 through 29, 1969 are the dates to keep in mind. Volunteer physicians are needed—please, contact Dr. Mozden or the office—736-0661. Plans are becoming very real. Many agencies have sent in their requisitions for booth space. The Steering Committee will meet on January 8, 1969, to formulize plans.

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DECEMBER EXECUTIVE COMMITTEE MEETING HIGHLIGHTS

The December 17th meeting of the Executive Committee was called to order by President Barnes at 8:04 P.M. Present were: Drs. Barnes, Stoler, Mozden, Boivin, Hough, Anton, Moore, Wiedman, Kelly, Suzor, Beauchamp, Jr., and Mrs. Purdy.

The minutes of the November meeting were read by Dr. Stoler and approved as read.

COMMUNICATIONS

Dr. Toutoungbi asked for remission of dues to study for one year. This was granted by the Committee.

A letter of thanks was read from Normand Tremblay, a scholarship recipient.

Dr. Stevens sent a copy of a suggestion on Regional Planning. A letter of thanks will be sent to Dr. Stevens.

Concentrated Employment Program sent a copy of a letter which was sent to a physician in the North End asking for cooperations with the CEP program on absenteeism. This was considered informational.

A letter of resignation from Dr. Hurley as Associate Editor of the *Hampden Hippocrat* was accepted with regrets.

OLD BUSINESS

Three physicians have indicated their interest as physician coordinator with the Connecticut Valley Health Planning Council. Dr. Lium will be so notified and another notice will go

out to the membership in the next *Newsletter*.

Dr. Moore reported on seeking funds for the Health Fair, '69. A further report will be given at the January meeting.

COMMITTEE REPORTS

A brief report of the Emergency Medical Service was given. There were 305 calls and 10 were actually referred to the emergency physician. This report has been sent to Dr. Williams, Chairman.

Dr. Suzor gave a report of the many replies from the Hampden County schools in regard to the drug abuse program which is to start in January.

Mrs. Purdy gave the office report. The Legislative committee, the Public Relations Committee of the Health Fair, '69 and the Censors meetings have been held in the Conference Room. Mrs. Purdy spoke at a meeting of the American Medical Women's Association in Boston, on "Communications at the Grass Root Level." The speaker's bureau will be asked to activate speakers on VD because of the increase in the disease.

The Committee instructed the Secretary to write the Censors to indicate the importance of attending the Censor meetings when held.

The meeting adjourned at 9:05 P.M. The Grievance Committee met and heard five cases. The meeting was adjourned at 10:30 P.M.

NEW DIRECTIONS

For a number of years, the Springfield Municipal Hospital has been diligently attempting to implement a program of comprehensive medical care for the chronically ill with the primary objective of restoration to as high a level of independence as possible. Various levels of medical care ranging from intensive to custodial have been provided by the Hospital's full time staff, supervisory visiting physicians, and consultants. Admissions have been based as much as possible on the medical needs of applicants and the Hospital's ability to meet them. The Hospital has attained accreditation as a chronic disease hospital from the Joint Commission on Accreditation of Hospitals, is licensed by the Commonwealth as a chronic disease hospital, and has been certified as both a hospital and an extended care facility for participation in Medicare by the Social Security Administration.

In the light of recent developments, the Hospital's Board of Trustees has been prompted to review its various policies. The following are some of the outstanding developments motivating the need for such a review. First of all, Title 18 and Title 19 of the Federal Public Law 89-97, commonly known as "Medicare" and "Medicaid" respectively, have set forth certain principles in a noble attempt to establish one standard of medical care for all citizens, namely, the best available to all requiring or in need of same. To further reinforce this principle, Public Law 89-239 was passed in 1965 establishing the regional medical programs and Public Law 89-749, in 1966 establishing the Comprehensive Health Planning pro-

grams. Secondly, Public Law 89-97 espouses the right of patients to free choice of available physicians, facilities, and services. Thirdly, the Commonwealth of Mass. in implementing the Title 19 ("Medicaid") program has assumed the obligation of paying for the medical care of those unable to provide for same through their own resources and thereby relieving the City of Springfield from its statutory obligation of providing medical care to the indigent.

In the light of the aforesaid, the Hospital's Board of Trustees has of late been appealing to the City's administration for a change in the enabling statutes establishing the hospital so that policies could be set similar to those of a voluntary facility in the chronic disease field particularly insofar as admissions are concerned. Unfortunately, a change in admission policy cannot be effected at the present time. Only clients of the Mass. Dept. of Public Welfare and the Springfield Veteran Services Dept. can be admitted. However, demand by the public in the not too distant future might stimulate the amendment of the enabling statutes establishing the Hospital so that admissions will be based mainly on medical need and not secondarily to economic need.

Conversations with the Mass. Bureau of Hospital Costs and Finances have led to an understanding that a physician on the Medical Staff of the Hospital could receive payment for the continued care of his respective patient in the Hospital on a fee for service basis. However, all patients in the Hospital would have to be under the personal care of a member

of the Medical Staff of the Hospital, and no payment would be made to the Hospital for the services of full-time House Staff Physicians.

In other words, the Medical Staff could be enlarged and its members could admit their Medicaid patients to and take care of them in the Hospital as so-called "private cases." Each physician would then bill the appropriate governmental agency for his services. There would be no "resident" or full-time physician coverage. The policies and procedures followed would be similar to those of a Medical Staff in a community voluntary hospital.

In the light of the aforesaid, the Hospital's Board of Trustees recently sent the following letter of inquiry to all Springfield physicians:

1. Would you be willing to apply

to the Medical Staff of the Hospital and seek privileges for admitting and taking care of your patients who are clients of the Mass. Dept. of Public Welfare or the Springfield Veteran Service Dept.?

2. If appointed, would you be willing to undertake duties of a member of the Active Medical Staff (i.e., Committee assignments, etc.)?

All physicians receiving the said inquiry are requested to return the enclosed addressed postcard as soon as possible so that appropriate planning can ensue. Those not having received the letter of inquiry or desiring more information, should contact the Hospital's administration in regard thereto.

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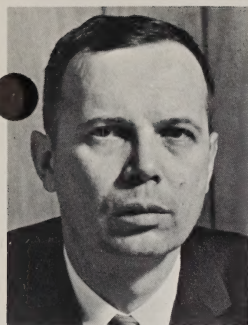
Name: Samuel Antiles, M.D.
Office: 15 Mulberry St.
 Springfield, Mass.
Born: Springfield, Mass. April 20, 1937
Medical School: Albany Medical College, 1962
Internship: Albany Hospital
Residency: Albany Hospital
Specialty: Internal Medicine



Name: John Paul Carroll, M.D.
Office: 476 Appleton St., Holyoke, Mass.
Born: Cliffside Park, New Jersey, June 28, 1925
Medical School: Albany Medical
Internship: Rhode Island Hospital
Residency: Rhode Island Hospital
Specialty: Orthopedic Surgery



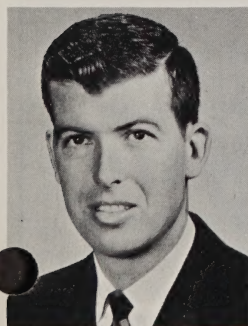
Name: William Stewart Frankl, M.D.
Office: 759 Chestnut St., Springfield
 Hospital
Born: Philadelphia, Pa., July 15, 1928
Medical School: Temple University School of
 Medicine
Internship: Buffalo General Hospital, Buffalo,
 N.Y.
Residency: Temple University—Internal
 Medicine
 Univ. of Penn.—Cardiology
 Hahnemann Medical College—
 Radioisotope Methodology
Specialty: Cardiology



Name: Ralph L. Kendall, M.D.
 Office: Wing Medical Associates, Palmer
 Elkins, West Virginia, June 21,
 1928
 Medical School: Medical College of Virginia
 Internship: Springfield Hospital, Springfield,
 Ohio
 Residency: Psychiatry, Bellevue Hospital,
 New York City
 Internal Medicine, Albany V.A.
 Hospital
 Pulmonary Disease, V.A. Hospital,
 West Haven, Conn.
 Specialty: Internal Medicine and Cardio-
 Pulmonary Disease



Name: Morris Marvin Hilf, M.D.
 Office: 159 Essex St., Holyoke, Mass.
 Born: Ellenville, N.Y., October 9, 1935
 Medical School: State University of Medicine,
 Syracuse
 Internship: Albany Medical Center
 Residency: Bellevue Medical Center, Cornell
 Division
 Specialty: Urological Surgery



Name: Gerald A. Wyker, M.D.
 Office: Johnson Memorial Hospital, Staf-
 ford Springs, Conn.
 Born: Cortland, New York, April 1, 1932
 Medical School: Ohio State University College of
 Medicine, 1961
 Internship: Riverside Methodist, Columbus,
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 Residency: Children's Hospital, Columbus,
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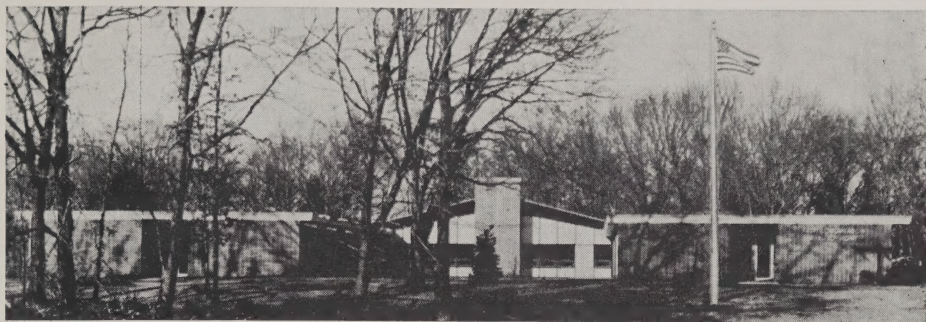


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